IC 12-15-11.5

Chapter 11.5. Lake County Disproportionate Share Hospitals

IC 12-15-11.5-0.5

Chapter not applicable to certain managed care contractors

Sec. 0.5. This chapter does not apply to a managed care contractor that, on or before July 1, 2000, did not directly contract with a hospital (as defined in section 1 of this chapter) for the provision of services under the office's managed care program.

As added by P.L.141-2001, SEC.1.

IC 12-15-11.5-1

"Hospital" defined

Sec. 1. As used in this chapter, "hospital" refers to an acute care hospital provider that:

(1) is licensed under IC 16-21;

(2) qualifies as a disproportionate share hospital under IC 12-15-16; and

(3) is the sole disproportionate share hospital in a city located in a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000).

As added by P.L.142-2000, SEC.2.

IC 12-15-11.5-2

Hospital as contracted provider to eligible individuals

Sec. 2. The office's managed care contractor shall regard a hospital as a contracted provider in the office's managed care services program, which provides a capitated prepayment managed care system, for the provision of medical services to each individual who:

(1) is eligible to receive services under IC 12-15 and has enrolled in the office's managed care services program;

(2) resides in the same city in which the hospital is located; and

(3) has selected a primary care provider who:

(A) is a contracted provider with the office's managed care contractor; and

(B) has medical staff privileges at the hospital.

As added by P.L.142-2000, SEC.2. Amended by P.L.141-2001, SEC.2.

IC 12-15-11.5-3

Incentives not permitted; compliance with eligibility verification and medical management programs

Sec. 3. (a) The office or the office's managed care contractor may not provide incentives or mandates to the primary medical provider to direct individuals described in section 2 of this chapter to contracted hospitals other than a hospital in a city where the patient resides.

(b) The prohibition in subsection (a) includes methodologies that

operate to lessen a primary medical provider's payment due to the provider's referral of an individual described in section 2 of this chapter to the hospital in the city where the individual resides.

(c) If a hospital's reimbursement for nonemergency services that are provided to an individual described in section 2 of this chapter is established by:

(1) statute; or

(2) an agreement between the hospital and the individual's managed care contractor;

the hospital may not decline to provide nonemergency services to the individual on the basis that the individual is enrolled in the Medicaid risk based program.

(d) A hospital that provides services to individuals described in section 2 of this chapter shall comply with eligibility verification and medical management programs negotiated under the hospital's most recent contract or agreement with the office's managed care contractor.

(e) This section expires December 31, 2004.

(f) Notwithstanding subsection (a), this section does not prohibit the office or the office's managed care contractor from directing individuals described in section 2 of this chapter to a hospital other than a hospital in a city where the patient resides if both of the following conditions exist:

(1) The patient is directed to a hospital other than a hospital in a city where the patient resides for the purpose of receiving medically necessary services.

(2) The type of medically necessary services to be received by the patient cannot be obtained in a hospital in a city where the patient resides.

As added by P.L.142-2000, SEC.2. Amended by P.L.141-2001, SEC.3; P.L.122-2002, SEC.1.

IC 12-15-11.5-4 Repealed

(*Repealed by P.L.1-2002, SEC.172.)*

IC 12-15-11.5-4.1

Reimbursement for services; inflation adjustment factor

Sec. 4.1. (a) A hospital that:

(1) does not have a contract in effect with the office's managed care contractor; but

(2) previously contracted or entered into an agreement with the office's managed care contractor for the provision of services under the office's managed care program;

shall be reimbursed for services provided to individuals described in section 2 of this chapter at rates equivalent to the rates negotiated under the hospital's most recent contract or agreement with the office's managed care contractor, as adjusted for inflation by the inflation adjustment factor described in subsection (b). However, the adjusted rates may not exceed the established Medicaid rates paid to Medicaid providers who are not contracted providers in the office's

managed health care services program.

(b) For each state fiscal year beginning after June 30, 2001, an inflation adjustment factor shall be applied under subsection (a) that is the average of the percentage increase in the medical care component of the Consumer Price Index for all Urban Consumers and the percentage increase in the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics, for the twelve (12) month period ending in March preceding the beginning of the state fiscal year.

(c) This section expires December 31, 2004.

As added by P.L.141-2001, SEC.4. Amended by P.L.122-2002, SEC.2.

IC 12-15-11.5-5

Repealed

(*Repealed by P.L.1-2002, SEC.172.)*

IC 12-15-11.5-6

Claim for reimbursement treated as disputed claim

Sec. 6. A claim for reimbursement for services shall be treated as a disputed claim under this chapter if:

(1) it is submitted within one hundred twenty (120) days after the date that services are rendered;

(2) it is denied by the managed care contractor;

(3) the hospital submits a written notice of dispute for the claim to the managed care contractor not more than sixty (60) days after the receipt of the denial notice;

(4) it is appealed in accordance with the managed care contractor's internal appeals process; and

(5) payment for the claim is denied by the managed care contractor following its internal appeals process.

As added by P.L.142-2000, SEC.2.

IC 12-15-11.5-7

Conclusion of appeal

Sec. 7. The office's managed care contractor must conclude an appeal under section 6(4) of this chapter and notify the hospital of its decision not more than thirty-five (35) days after the managed care contractor receives a notice from the hospital disputing the managed care contractor's denial of a claim.

As added by P.L.142-2000, SEC.2.

IC 12-15-11.5-8

Dispute resolution procedure requirements

Sec. 8. (a) A contract entered into by a hospital with the office's managed care contractor for the provision of services under the office's managed care services program must include a dispute resolution procedure for all disputed claims. Unless agreed to in writing by the hospital and the office's managed care contractor, the dispute resolution procedure must include the following

requirements:

(1) That submission of disputed claims must be made to an independent arbitrator selected under subsection (b).

(2) Each claim must set forth with specificity the issues to be arbitrated, the amount involved, and the relief sought.

(3) That the hospital and the office's managed care contractor shall attempt in good faith to resolve all disputed claims.

(4) The hospital shall submit to the arbitrator any claims that remain in dispute sixty (60) calendar days after the hospital receives written notice as provided under section 7 of this chapter.

(5) That resolution of disputes by the arbitrator must occur not later than ninety (90) calendar days after submission of disputed claims to the arbitrator, unless the parties mutually agree otherwise.

(6) That determinations of the arbitrator are final and binding and not subject to any appeal or review procedure.

(7) That the arbitrator does not have the authority to award any punitive or exemplary damages or to vary or ignore the terms of any contract between the parties and shall be bound by controlling law.

(8) That judgment upon the award rendered by the arbitrator may be entered and enforced in and is subject to the jurisdiction of a court with jurisdiction in Indiana.

(9) That the cost of the arbitrator must be shared equally by the parties, and each party must bear its own attorney and witness fees.

(b) The parties to a contract described in subsection (a) shall mutually agree on an independent arbitrator, or, if the parties are unable to reach agreement on an independent arbitrator, the following procedure must be followed:

(1) Each party shall select an independent representative, and the independent representatives shall select a panel of three (3) independent arbitrators who have experience in institutional and professional health care delivery practices and procedures and have had no prior dealing with either party other than as an arbitrator.

(2) The parties will each strike one (1) arbitrator from the panel selected under subdivision (1), and the remaining arbitrator serves as the arbitrator of the disputed claims under subsection (a).

(3) The procedures for selecting an arbitrator under this section must be completed not later than twenty (20) calendar days after the hospital provides written notice of at least one (1) disputed claim.

As added by P.L.142-2000, SEC.2.

IC 12-15-11.5-9

Arbitration process to be followed for disputed claims between hospital and managed care contractor

Sec. 9. The arbitration process described in section 8 of this chapter shall also be followed for resolution of disputed claims between a hospital and the office's managed care contractor, if the hospital is not a contracted provider in the office's managed health care services program.

As added by P.L.142-2000, SEC.2.